

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006989

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1272 STATE FILE NUMBER

FILED MAR 15 1963

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI | | Length of stay in 1b 46 Years | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital, KC, MO. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. CITY OR TOWN KANSAS CITY, MO. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. STREET ADDRESS 5114 E 34th St, Kc, Mo. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last OSCAR MARTIN SCOTT | | 4. DATE OF DEATH Month Day Year FEB. 22, 1963 | |
| 5. SEX MALE | 6. COLOR OR RACE negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9/23/96 |
| 9. AGE (last birthday) 66 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED | |
| 11. BIRTHPLACE (City and state or country) NEW ALBANY, IND. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME JOHN SCOTT | | 13b. MOTHER'S MAIDEN NAME LILY CONLEY | |
| 14. NAME OF HUSBAND OR WIFE MARGARET SCOTT | | 17. INFORMANT VA Hosp. Records MRS MARGARET SCOTT, 5114 E 34th Kc, Mo. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 9/1/18 to 1/8/19 | | 16. SOCIAL SECURITY NO. [REDACTED] | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Status asthmaticus DUE TO (c) [REDACTED] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) [REDACTED] | | INTERVAL BETWEEN ONSET AND DEATH [REDACTED] | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) [REDACTED] | | 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year [REDACTED] | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) [REDACTED] | |
| 20f. CITY, TOWN, OR LOCATION [REDACTED] | | COUNTY [REDACTED] STATE [REDACTED] | |
| 21. I attended the deceased from 2/14/63 to 2/22/63 Death occurred at 3:10 PM 2/22/63 on the date stated above, and to the best of my knowledge, from the causes stated. | | 22. SIGNATURE (Degree or title) R.H. Owings, M.D. [Signature] | |
| 22b. ADDRESS VA Hospital, Kansas City, Mo. | | 22c. DATE SIGNED 2-23-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 2-28-63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery | | 23d. LOCATION (City, town, or county) (State) Kansas City Kansas | |
| 24. FUNERAL DIRECTOR Nathan W. Thatcher K.C.K. | | 25. DATE RECD. BY LOCAL REG. 2-25-63 | |
| 26. REGISTRAR'S SIGNATURE [Signature] | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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| VS 300 Rev. 4/59 | DATE AMENDED | |
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Clifford L. Woods

Licensed Embalmer No. 3106

P.O. Address 1520 N. 5th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.